RENEWAL APPLICATION FOR LICENSE
APPROVAL TO OPERATE A HOSPICE

State Form 49883 (R/4-03)
Indiana State Department of Health-Division of Acute Care
Form Approved By State Board Of Accounts-2003

Division of Acute Care Use Only

Date Received_____ **Date Approved**_____ **Approved By**_____

All questions on this application must be answered completely and legibly with printed or typed script with supporting documentation attached when applicable. Incomplete or illegible applications will be returned without being processed. A non-refundable application fee in the amount of $100.00 must accompany this application. No license or approval shall be issued without receipt of this fee and/or completed application.

Please Type or Print Legibly

SECTION I - FACILITY NAME AND ADDRESS

Facility Name/Address Identification Label	**If there are any changes to the name of the facility and/or address as listed on the Name/Address Identification Label, please make corrections below. In addition, submit a letter to this division with the name and/or address changes and the effective date of these changes. Upon receipt of correspondence changing the name/address, this division will send a confirmation letter.**

A. Practice Location *(facility)*
Complete if changes are different from the above identification label

Name of Facility			
Street Address			P.O. Box
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Effective date of name change	Effective date of address change

SECTION II- MANAGEMENT

If there are any changes in your management, attach a resume, current Indiana applicable license, current criminal history check, and a letter with the effective date of the staff changes.

Administrator Name	Medical Director Name
Patient Family Care Coordinator Name	

SECTION III – OTHER SITES

Does the facility have other sites? Yes No
If yes, please provide the name, address, and telephone number of each site location. *(use additional sheet if necessary)*

Name	Address (street address/city/zip)	Telephone Number

SECTON IV - OWNERSHIP INFORMATION

A. Applicant Entity (Owner/Operator)
If a change of ownership has occurred, you must submit a change of ownership application to this division.

Name of Applicant Entity-Licensee *(operator(s) of the facility)*

B. Ownership Information (officers/directors/managing agents/managing employees of the home health agency)

Has the facility changed individuals with direct or indirect ownership? Yes No *(If yes, complete below)*

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address (street address/city/state/zip)	EIN Number

C. Type of Entity

For Profit

Individual
***** Partnership
****** Corporation
******* Limited Liability Company
Sole Proprietorship
Other *(specify)*_____
_____

NonProfit

Church Related
Individual
***** Partnership
****** Corporation
******* Limited Liability Company
Other *(specify)*_____
_____

Government

State
County
City
City/County
Hospital District
Federal
Other *(specify)*_____

D. Directors/Officers/ Partners/Managing Agents/Managing Employees *(Director owners)*

Has the facility changed officers, partners and/or directors? Yes No *(If yes, complete below)*

List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, president, vice president, secretary, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

Officer/Partner/Director Name	Title	Business Address (street address/city/state/zip)	Telephone Number

SECTON V - CERTIFICATION OF APPLICATION

I hereby certify that operational policies of this facility will not provide for discrimination based upon race, color, creed, or national origin.

I swear or affirm that all statements made in this application, and any attachments thereto, are correct to the best of my knowledge and that I will comply with all laws, rules and regulations governing and licensing of hospice programs in Indiana.

Applicant's signature as indicated in section II of this application, or signature of applicant's agent, should appear below.

If signed by any individual (e.g., the administrator) other that indicated in section II of this application, an affidavit must be submitted with the application to affirm that said person has been given the power to bind the applicant/licensee.

Name of Authorized Representative (Typed/Printed)	Title

Signature of Authorized Representative	Date *(month/day/year)*

RETURN APPLICATION AND A NON-REFUNDABLE LICENSE FEE OF $100.00 TO:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER, 2ND FLOOR
2 NORTH MERDIAN STREET
INDIANAPOLIS, INDIANA 46204-3003